Teaching Pediatric Psychiatry to Medical Students

Technical and Affective Dimensions

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Abstract. To aid in their development as more aware and therapeutic physicians, medical students are exposed to intensive, supervised participation in the diagnostic evaluation of a child. Basic principles and methodology of the model are described. Consideration is given to the role and contributions of each member of the teaching team, with particular attention to the timing and integration during the week's learning process. The meaning and management of student-teacher interactions, and of individual responses to the clinical situation, are discussed.

The integration of skills and attitudes from psychiatry into the fundamental training of new physicians poses a continuing challenge to medical education. This paper reviews the methods and rationale of a teaching program in pediatric psychiatry which for over two decades has been an integral part of clinical clerkships at the Children's Hospital National Medical Center, the main site for training in pediatrics at the George Washington School of Medicine. We introduce this experience at the point of the medical students' first clinical involvement with children and their families

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in the hope that psychiatric (or, more appropriately, mental health) approaches will become basic parts of their total role as physicians. We also hope to help students to begin to look beyond the immediate boundaries of a specific illness to the social context of their patients' lives. In this sense, the goal is not to teach the medical discipline of psychiatry as such, but to offer its principles as a bridge to a broader medical-social model of functioning.

Design and Purposes

Students are actively involved in the program throughout the 8-week clerkship in pediatrics. They participate in two complementary ways:

1. Students are assigned in pairs to the Department of Psychiatry for a week of full-time work with a special interdisciplinary team. They carry out a traditional full-scale diagnostic evaluation of a child or adolescent. Each patient is selected because of problems related to pediatric practice, e.g., psychophysiological reactions, responses to organic conditions or emotionally based processes interfering with general development. The students carry out or observe each part of the evaluation, with the staff sharing in the work and providing coverage at various points to safeguard the patient's interests and to assure high-quality service.
2. Every Friday, all the clinical clerks in pediatrics attend a teaching conference at which the results of the work-up are presented by the diagnostic team. The conference is led by a senior attending psychiatrist who specifically orients it to the entire group of students.

This model has been fashioned for a number of purposes: (1) to introduce into the students' fundamental clinical approach to children and families an appreciation of behavioral and developmental problems and a technical orientation to dealing with them; (2) to stimulate them to integrate concepts of constitutional influences with those of personality formation and mental development; (3) to bring psychiatric "cases" and problems into the context of normal and deviant functioning of children and families and to relate such problems to the broader psychological aspects of medical practice; (4) to help the students to begin to understand children and other family members as individuals, to teach them to become aware of defenses, and to show them how to look under the surface of behavior for its meaning. We do not expect the students to interpret unconscious determinants of behavior. Rather, we try to demonstrate the existence and importance of forces outside the patient's

and doctor's awareness and to enable the student to see these vectors as influencing physical and psychological functioning; (5) to inform the students about how children communicate and how to begin to respond to these communications as meaningful and important; (6) to orient these future physicians to the importance of collaborative work with other disciplines and to the network of social and community resources which can be mobilized on behalf of their patients; and (7) to give attention and emphasis to the interpretive process, the means by which a physician tells a family about findings and plans for treatment. This is an aspect of the physician's role whose importance is matched only by its relative neglect in his education (Werkman, 1961).

Since the inception of this program by Lourie and Berman in 1948 (Berman, 1956), the teaching staff has been aware that the students' acceptance or rejection of what they are taught will be critically influenced by their responses on the affective level. We aim, therefore, at an approach which gives each student the maximum yield which his individual personality will permit. This means that each component task and supervisory input has to be structured to provide the technical means and affective experiences which will enable the student to do the job at hand well and then to move on to the next one.

At a designated point in time each teacher must deliver information reliably and help the students with expressed feelings and reactions, appreciating that this contribution is but one step in the sequence of their learning. The teaching team members must individualize their approaches to the needs and abilities of each student and strive to remain aware of the affective forces at work in deciding how best to use the clinical material for technical instruction.

The Program in Operation

We shall illustrate the applications of these guidelines by following the course of a typical week in some detail.

The pair of students on rotation starts off by spending Monday morning with the social worker who coordinates the program. Her mission at this point is to orient them to the Department and its physical setting and to the team concept in child guidance work. She then begins to prepare them for the first history-taking session that afternoon.

Many of the students are available and interested in seeing what the week's experience will offer. This does not mean that they are

uncritically accepting of psychiatry in general or this highly structured program in particular. As is true with others of their generation, they may be against the establishment, they may challenge what they see as conventional roles, and they are often concerned about the relevance of their training to the broad social issues of the day. Some have previously observed psychiatrists demonstrate the psychopathology of very sick adults and are reluctant to share a role which they view as getting people to reveal themselves so that they can be categorized. Or they may question the reality, validity, and usefulness of psychiatric principles, especially as a means of bringing real help to deprived populations. In addition, they may be concerned about having a tangible work identity as physicians by means of which they can make a real contribution. Despite careful instruction in the preclinical years, many students arrive at the junior and senior years feeling that they know nothing about psychiatry. This is especially difficult for those who are, in their own words, "technicians" rather than "humanists." Such students may start off seeing things more from the patient's side than is usual in other clinical relationships. A small number of students begin the week with a rejecting broadside against the very idea of a rotation in psychiatry or with a barrage of hostile skepticism about technical points. Others actively deny the value of the social worker as a teacher or of her knowledge of anything which they do not already know. More commonly, unavailable students present themselves as bland, restrained, detached, or politely debunking.

The social worker adjusts her style to what the students give her both in words and in nonverbal cues. Her perception of the students' affective responses helps her to deal with them and the case material in a manner which provides them a model for dealing with patients. Thus, they will soon have to interview parents in depth, while providing them personal support in coping with anxiety. The social worker starts off fresh in reviewing the referral data and carefully avoids the appearance of an omniscient attitude about the case. She avoids talking down to the students and encourages them to consider possible meanings of the available information. Their questions are answered on the concrete level rather than with interpretive speculations. She then covers the essentials of a developmental history, emphasizing the importance of the social context of patients' lives. Students are not given a rigid, all-inclusive outline to follow. Rather, they are helped to focus upon the interview situation, the parents' thoughts and feelings about bringing their child to a psychiatric facility, and the need to strike a balance between excessive pressure for data on the one hand and

avoidance of painful areas on the other. The coordinator tries to bring resistances out into the open. She deals with them by a conscious emphasis on the needs of the child and family and by clarifying her own share of the responsibility for good care. Students are provided opportunities to raise questions and to express their uncertainties and are reminded of how much they already know about taking histories and seeing patients in one-to-one situations.

They themselves decide who will interview the parents and who will do the diagnostic interview with the child. After the first history-taking session with the parents, the students meet again with the social worker. At this time, they tend to report with little overt affective expression. However, the interviewer's way of describing the parents and presenting "the facts," and his partner's responses, may give the social worker clues to the influences of biases and resistances. She attends to these to highlight areas of history meriting further attention.

On Tuesday morning, both students observe the clinical psychologist's examination of the child, with a few minutes for questioning afterward. The psychologist functions here as their colleague in the diagnostic process. In this way, she demonstrates the collaborative approach and the fact that there are different methods and sources for collecting clinical information. The psychologist's participation is scheduled at this point in the week for a number of reasons. It allows her to note and suggest to the students areas to follow up in the school visit, playroom interview, or further history taking. She might focus on constitutional problems in perceptual-motor integration, on impulsivity, or on depressive signs. To safeguard the patient, she also alerts the rest of the teaching team to such areas. On the affective level, this introduction to the child, along with a chance to witness his favorable response to someone else dealing with him competently and kindly, are also valuable to the students. It gives them a direct role model and lowers their resistances, whether due to identification with the child or to their understandable anxiety about coping with someone known so far only from the negative referral report.

During the psychological evaluation, the students are more interested when they can see something concrete being produced by the child than when there are only verbal responses. Thus, Bender-Gestalts and figure drawings seem more tangible and vivid than the nuances of testing and the projective approaches, which they will come to appreciate only later.

Upon returning from escorting the child to the waiting room, the psychologist often finds the students poring over the TAT and

Rorschach cards on her desk. In the few minutes available for questions, some students are receptive and spontaneously try to integrate what they already know. Others are suspicious, directly question the test's validity, or criticize the psychologist for invading the child's privacy. Some even suggest that psychology can be used in evil ways. The psychologist defers dealing with these issues until the following day.

The students' Tuesday afternoon visit to the child's school is generally a very positive experience. It allows them to function in comfortable physicians' roles. As "doctors," they are welcomed by school personnel who volunteer information, seek reassurance, and treat them as experts. Sometimes, too, this visit serves further to balance overidentification by showing what the poor victim, as he may be regarded in the clinic, does to others. Contacts with social agencies later in the week may be similarly useful for the students' exposure to allied professionals trying to help the family, often under pressures akin to those confronting the students themselves.

The playroom interview comes the next morning (Wednesday). An hour in advance, both students meet with the child psychiatrist who supervises this part of the evaluation. His task in the hour is to give the student interviewer a framework for determining what information he wants, how to go about getting it, and how to identify and deal with his own and the patient's feelings. The supervisor always asks for a summary of what is known about the child and family, encouraging the students' activity and sense of "ownership" of the case. The child's probable reactions and the content and techniques of an appropriate playroom session are reviewed. Reference is made to the types of play characteristic of different ages, since students use play better when alerted to its developmental significance, meaning, and function. This discussion may also increase their overall comfort with unfamiliar techniques.

The psychiatrist consistently offers support and a model for identification. He also maintains a level of tension which will encourage ventilation and self-observation. Beyond this, he watches for clues to individual needs in tailoring his approach to the students. By now, many have become freer in communicating. Some do so by finding the typically cluttered office-playroom unusually barren or cold. Most can more specifically express conscious fears of not knowing how to relate to a child, of traumatizing him or of being unable to get enough data. Beginning awareness of the child's power may come out in concerns about not being able to get him to talk or play or not being able to handle his feelings. Some students can acknowledge their concerns and move on to ask about

interviewing. They anticipate problems and think about the child's side of the interaction. Others may remain preoccupied and unresponsive, dwell on unrelated formal issues or deny any need for preparation.

The supervisor engages the students in a discussion of how best to approach the child's feelings and fantasies about the interview. Those who are uneasy about it themselves may show resistance to recognizing and following up the child's feelings. This may be handled by referring to stressful interviews in the student's own life, e.g., when visiting the doctor as a child or when applying to medical school. Considering what an interviewer or an examining physician could have done to make him feel more at ease can aid the student to consider how to deal supportively with an anxious child. He can then usually also think of ways to elicit factual and fantasy content.

Most students come out of this hour no longer concerned about the supervisor's sitting in on the diagnostic session. As one put it, "I would have been anxious before, but now I feel I know you and I'm not bothered."

During the playroom interview, the supervisor tends to remain silent and makes comments only when there are clear and specific indications. Mostly, these arise when the student seems to need help in order to be able to proceed, e.g., if he cannot think of anything else to ask or when the child is mute, extremely guarded, or defensive. Sometimes the supervisor will also demonstrate interviewing technique, particularly regarding affective elements or potentially sensitive content. When accurate and well-timed, such interventions catalyze the student-patient interaction. Usually, both become more open and at ease about midway through the interview, often after some focus on feelings.

Both students join in a short postplayroom discussion with the psychiatrist and the social worker-coordinator. Students may deprecate their own ability to get direct information or say that the psychiatrist did much of the work. Nevertheless, most are surprised at the child's openness, the positive relationship they were able to establish, and the amount they really learned. The student who saw the child may decide to see him again, on his own.

During this "debriefing," the students renew their relationship with the coordinator at a level of greater comfort and trust. A little later, when the social worker meets alone with them to make sure that the rest of the work-up is underway, some can present negative feelings in a way which now invites discussion. They may even

spontaneously raise general questions about the case, about psychotherapy or conceptual issues in psychiatry.

In the afternoon there is an extended session with the psychologist, who now functions more in a teaching role. Beginning on the same level of observed data which has characterized all the teaching until now, the psychologist reviews the results of her test battery. She then enlists the students to active participation in fitting together the findings and in formulating appropriate impressions from them. The students' initial reactions to the different tests vary. Projective test results in particular tend to evoke denials of the significance of the child's responses. The psychologist simply states her belief in her viewpoint without the excessive defensiveness which might remobilize resistances. Instead, she draws attention back to the observed behavior, insisting that the students work out conclusions based on data rather than on theory or on their own preconceptions and attitudes. As they become active in doing this, their interest in the material quickens and they begin to recognize the validity of the process. This is reinforced by the psychologist's ability to demonstrate that her results are consistent with those from other parts of the work-up. The session is also a step toward learning clinical inference, an experience which is to be repeated full-scale at the group diagnostic conference where all the available information is assimilated and integrated. The psychologist knows that at this stage some students will regard her, with her collection of tangible instruments, as the truly "scientific" member of the team, and will look too readily to her for mystical answers and easy shortcuts. When this occurs, she points out that her findings are only part of a process yet to be completed.

The next morning's session with the social worker concentrates on preparing for the diagnostic conference. Despite having attended such conferences earlier in the clerkship, some students now react as though this will be altogether new to them. A few even seem to be anticipating a *viva voce* doctoral exam. Others want procedures minutely reexplained. They do not voice overtly concerns about personal adequacy and do not seem to hear attempts at reassurance. The social worker stresses that the students' job is to record factual observations, not to produce dynamic formulations. She reiterates that their work will be part of a permanent clinical record and encourages them to take active steps to fill in any pieces they think may be missing. She also reminds them that she will need their information for her own follow-up with the parents.

Most students are surprised at the difficulty they encounter in

doing the write-up and at how much they care about doing it well. The more comfortable ones usually come in early on Friday to seek out the social worker and to ask her approval of their work. Others come in late, drop the case protocol on her desk and run.

The Friday conference has the traditional function of helping the psychiatric diagnostic team arrive at official impressions and recommendations in order to complete their services to the family. In this program, however, its primary orientation is toward the entire group of clinical clerks in pediatrics, in whose ranks the pair on the week's concentrated rotation really belongs. The material gathered by them is of a breadth and complexity to which their peers are largely unaccustomed. It is the conference chairman's task, therefore, to make it relevant to the group as a whole, to help them to integrate it, and to involve them in developing practical applications of psychodynamic theory to medical practice. As the data are presented, the chairman mobilizes all the students to discuss possible meanings and to relate them to their own experiences. In the group's interaction, the material assumes a central and powerful role; in effect, it comes to speak for itself. The resistances of individual members are thereby confronted by the data, rather than by the leader, who could do so only with difficulty if at all. The group vehicle is also effective in increasing tolerance for anxiety-laden material and illuminating countertransference elements in the doctor-patient relationship. If a particular individual's difficulties surface, they are quickly neutralized through humor and group support. Such peer support, we should note, also characterizes the relationship of the pair to each other throughout the week and is relatively immune to one or the other's technical failures or emotional distress. The presenting students, freed of the job of recording the conference, can share fully in the close identifications of the group, which helps them to extract from the discussion what they can bring to the family in the interpretive session.

Next comes the preinterpretive teaching session with the social worker and senior fellow in child psychiatry who served as official recorder at the conference. It may begin with a review of the validity of the conference's conclusions and the workability of its recommendations. The students then are given technical guidelines for the interpretive process. These include: (1) recognizing the presence and implications of high emotional tension and guilt in the parents; (2) giving "the facts" in a way which avoids flat statements about the unconscious whose threat may stimulate anxiety and resistance; (3) the need to use comprehensible language; (4) the limits of how much the doctor can really give, despite efforts to

seduce him into magical postures; (5) means of preparation for treatment and the roles and responsibilities of both parent and child in it.

This discussion crystallizes the students' relationship with the coordinator. The majority can now accept directives about structuring the interview so as to move the parents into it gradually and to give them appropriate support and reassurance. Such students have grasped that their role should include helping patients to explore both the facts and their own feelings about the child's clinical problem.

Most students conduct the interpretive session in a way which their patients find of real service and leave the program with a feeling of a job well done.

Discussion

In overview, we see this program as a series of integrative steps. Each step involves students in consolidating previously acquired information and adding to it. The process is catalyzed by the presence of role models who give students relevant technical teaching tuned in to their affective functioning. While reflecting the department's overall approach to trainees from a range of backgrounds and experience (Lourie, 1962), it makes special demands on staff because of its compressed time frame and the great dependence of each step on what has gone before.

We include both male and female members in the teaching team, since some students will turn more readily to one than the other.

Each team member must be committed to the collaborative model and understand and respect how his contribution fits into the continuum of learning. The teachers must maintain a flow of observations about the students and patients through frequent informal contacts reinforced by team meetings.

Staff must be prepared for intensive emotional involvement which will parallel that of the students and be ready to call upon each other freely for knowledge and support.

Since the work often entails being a listening ear to students at points where their anxieties are high, it is usually essential that a staff member's background include skills in psychotherapy. These are not, we should emphasize, used to analyze or treat the students, but rather are flexibly applied to help them understand their own reactions so that they may understand their patients better.

The frequent occurrence of triangular situations at many levels makes additional demands upon teachers to show that they care

about all the people involved, lest their positions be distorted to the detriment of learning.

As its first representative and the only constant figure throughout the program, the social worker-coordinator experiences these demands most intensely and is required to shift most rapidly to keep up. At times, she sees the students' movement during the week as resembling those of a small lifetime.

This program, essentially as described here, has been a going concern for 24 years, with some modifications which have emerged from accumulated experience or from changes in the medical school's clerkship pattern. We feel that the teaching model has been meaningful for our students in terms of expanded horizons as physicians and of the personal satisfactions derived from mastery of anxiety, task completion, and enhanced abilities. The illustrative generalizations included here obviously cannot capture the full flavor of individual responses. There continues to be ample feedback to suggest that the experience does not fade quickly. This may be in the form of enthusiastic greetings and reminiscences at times and places far removed from the hospital, of subsequent referrals of patients, or of students coming back the next year for a month's elective to "learn to be better pediatricians," surgeons, etc. As a final note, we have even found that some of those who fought out their resistances within the program most vehemently have gone on to seek graduate training as psychiatrists, suggesting that the process has effectively stimulated thinking (if not "working") through. Perhaps the best summary statement might come from the anonymous evaluations which clinical clerks hand in to the Professor of Pediatrics. Over and over, they have expressed appreciation for an experience which is structured, yet at the same time allows them to air the doubts, fears, and resistances which cause them to turn away from the feeling side of their patients.

Summary

The introduction of some values and skills from psychiatry into the developing physician's personal and professional identity is a challenge for individualized teaching on both the technical and affective levels. Regardless of the specialty they may eventually choose, our aim is to prepare our students to become more aware and therapeutic physicians. Toward this end, we have exposed them to an intensive participation in the diagnostic evaluation of a child taught by an interdisciplinary collaborative team. Each team member relates to the students during a sequence designed to provide useful

information and to promote desirable attitudinal changes and identifications. The interaction of students' personalities with the content of the week's work has primary emotional aspects and calls for the flexible application of psychodynamic principles in the teaching process. We believe that this kind of experience during medical education can significantly enhance the student's growth into a complete physician.

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